Exhibit K

ADDITIONAL BUDGET DETAIL INVOICE TEMPLATE

CA Department of Health Services
Cancer Detection Section
Contract Analyst:
MS 7203
P.O. Box 997413
Sacramento, CA 95899-7413

Check if Final Invoice ( )
Contract Number:
Term of Contract:
Period of Invoice:
Invoice Number:

Date:
Agency Contact:
Agency Name:
(Address)

	BUDGET CATEGORIES (1)			APPROVED BUDGET (2)	ACTUAL EXPENSES THIS PERIOD (3)	CUMULATIVE EXPENSES TO DATE (4)	UNEXPENDED BALANCE (5)
A.	**PERSONNEL**	**% of Time**	**Salary Range**				
	1. Program Coordinator (Name)	100%	$6,334 - $6,984				
	2. Clinical Coordinator Supervisor (Name)	100%	$5,842 - $6,872				
	3. Clinical Coordinator Supervisor (Name)	100%	$5,842 - $6,872				
	4. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	5. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	6. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	7. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	8. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	9. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	10. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	11. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	12. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	13. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	14. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	15. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	16. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	17. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	18. Clinical Coordinator (Name)	100%	$5,672 - $6,760				
	19. Health Educator (Name)	100%	$3,287 - $4,588				
	20. Health Educator (Name)	100%	$3,287 - $4,588				
	21. Health Educator (Name)	100%	$3,287 - $4,588				
	22. Health Educator (Name)	100%	$3,287 - $4,588				
	23. Clerical Support (Name)	100%	$2,117 - $3,219				
	24. Clerical Support (Name)	100%	$2,117 - $3,219				
Total Salaries							
B.	**FRINGE BENEFITS** (at __% of Total Salaries)						
Total Personnel Expenses							
C.	**OPERATING EXPENSES**						
	1. General Expenses						
	2. Space Rent/Lease (Sample calculation - 100sq. ft x 24 FTEs x $2.50/sq.ft. x 12 mos.)						
	3. Printing/Photo Copying						
D.	**EQUIPMENT EXPENSES**						
	List if any						
E.	**TRAVEL and PER DIEM** (at State DPA Rates)						
F.	**SUBCONTRACTS/CONSULTANTS**						
	1. Community Health Worker (Name)						
	2. Community Health Worker (Name)						
	3. Community Health Worker (Name)						
	4. Community Health Worker (Name)						
	5. Community Health Worker (Name)						
	6. Community Health Worker (Name)						
	7. Community Health Worker (Name)						
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	9. Community Health Worker (Name)						
	10. Community Health Worker (Name)						
	11. Community Health Worker (Name)						
	12. Community Health Worker (Name)						
	13. Community Health Worker (Name)						
	14. Community Health Worker (Name)						
	15. Community Health Worker (Name)						
	16. Community Health Worker (Name)						
G.	**OTHER COSTS**						
	TOTAL DIRECT EXPENSES						
H.	**INDIRECT EXPENSES** (≤ 12% of Total Direct Expenses)						
	TOTAL INVOICE AMOUNT						

_____ _____
Authorized Agency Signature Date